**U.S. Department of Labor**

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

**Issue Date: 28 February 2006**

---

In the Matter of:

ROBERT C. SMITH,
Claimant

v.

C&O MINING, INC.,
Employer

and

HARTFORD CASUALTY INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No. 2004-BLA-5217

---

Appearances:

Joseph Wolfe, Esq.
Wolfe, Williams & Rutherford
Norton, Virginia
For the Claimant

Russell Vern Presley, Esq.
Street Law Firm
Grundy, Virginia
For the Employer and Carrier

Suzanne Brennan, Esq.
Office of the Solicitor
Arlington, Virginia
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

## DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Robert Smith, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 27, 2004, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 8. Director's Exhibits ("DX") 1-51, Claimant's Exhibits ("CX") 1 and Employer's Exhibits ("EX") 1-4 were admitted into evidence without objection. Tr. at 10, 11, and 13. The record was held open after the hearing to allow the parties to submit additional evidence and argument. By *Order* dated April 28, 2005, Employer's Exhibit 5, which is Dr. Wheeler's interpretation of a July 21, 2004 x-ray study, was admitted into the record. The Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

### PROCEDURAL HISTORY

The Claimant filed this claim on May 8, 2002. DX 1A. The Director issued a proposed Decision and Order Award of Benefits – Responsible Operator on August 5, 2003. DX 43. The Employer appealed on August 15, 2003. DX 45. The claim was referred to the Office of Administrative Law Judges for hearing on November 6, 2003. DX 49.

### APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2005).

## ISSUES

The Director does not contest any issues. However, the issues contested by the Employer are:

1. Whether the claim was timely filed.

2. Whether the Claimant worked as a "miner."

3. Whether the Claimant had post-1969 employment.

4. How long the Claimant worked as a miner.

5. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

6. Whether his pneumoconiosis arose out of coal mine employment.

7. Whether he is totally disabled.

8. Whether his disability is due to pneumoconiosis.

9. Whether the named Employer is the Responsible Operator.

10. Whether the named Employer has secured the payment of benefits.

11. Whether the Claimant's most recent period of cumulative employment of not less than one year was with the named Employer.

DX 49. The Employer also reserved its right to challenge the statute and regulations. DX-37. At the hearing, the Employer withdrew its controversion of whether Claimant worked as a "miner" and whether he engaged in post-1969 coal mine employment. Tr. at 8.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Factual Background and the Claimant's Testimony

On the CM-911a, the Claimant stated that his last coal mine employment was in the Commonwealth of Virginia. DX 2. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

While his claim was pending before the District Director, Claimant was deposed on October 25, 2002 at the Employer's request. DX 34. He testified that he married Judy Gay on March 1, 1970. DX 34 at 3-4. He has two children, but neither of them is dependent on him for support. DX 34 at 4. He last worked for Canada Coal Company until 1997 when a doctor told him he was disabled because of his lung condition. DX 34 at 4.

Claimant's last coal mining jobs were operating the continuous miner and working as an electrician. DX 34 at 6. He stated:

> [T]he continuous miner operator . . . digs the coal and loads it out. Electrician is doing the electrical repairs.

DX 34 at 6. The miner testified that he did not do very much heavy lifting, but the coal tunnel was three and one-half feet high and he had to crawl "[a]ll day." DX 34 at 6. He further recalled that, everyday on the job, he had to move heavy cable. DX 34 at 16. Claimant testified that he worked in the mines for 25 to 26 years. DX 34 at 10. He started working in the mines on July 15, 1970 or 1971. DX 34 at 10.

Prior to working for Canada Coal, the miner worked for C & O Mining. DX 34 at 7. He thought that he worked for C & O Mining for more than one year as a miner operator and electrician. DX 34 at 7. Claimant recalled that he suffered a back injury while working for C & O Mining where he "[p]ulled a miner cable in mud and water and (his) feet slipped out from under (him) and that's where it all happened." DX 34 at 8. As a result, Claimant was off from work and received workers' compensation benefits. DX 34 at 8. He testified that his estimate that the worked for C & O Mining for more than one year included only time he actually worked "[bec]ause on your work history and stuff like that, time you're off don't . . . count as on the job." DX 34 at 9. He did not recall that C & O Mining was ever "shut down" when he was working for the company. DX 34 at 10. He worked five to six days per week. DX 34 at 10. When Claimant left C & O Mining and went to Canada Coal, it was because Canada Coal paid more money and he did not have any "down time" between the jobs. DX 34 at 11.

It was noted during the deposition that Claimant's Social Security records showed that he was paid by C & O Mining in 1996 and 1997. DX 34 at 11. Claimant was asked whether his pay was ever held for a period of time and he replied that he was paid weekly and his pay was not held. DX 34 at 11-12. Therefore, he stated that, if the Social Security records show earnings in 1996 and 1997, then he worked for C & O Mining in both years. DX 34 at 11-12.

Claimant testified that he took one blood pressure pill as well as two inhalers, Proventil and Combivent. DX 34 at 14-15.

Claimant testified that no physician ever told him he had "black lung"; rather, his treating physician at the time he worked in the mines, Dr. Kawatley, advised that he suffered from chronic obstructive pulmonary disease. DX 34 at 15.

With regard to his smoking history, Claimant acknowledged that he smokes between one-half and three-quarters of a pack of cigarettes per day. DX 34 at 15. He started smoking at the age of 16 or 17 years old. DX 34 at 15.

Claimant then testified at the hearing on October 27, 2004. He stated that, although he is not formally separated from his wife, she lives in Virginia and he lives in North Carolina. *Tr*. at 19. They have lived apart for about one and one-half years. *Tr.* at 19. There is no court-ordered

support, but $1,700 or $1,800 of his Social Security benefits are sent to his wife each month. *Tr.* at 19.

Claimant recalled that at the time he left the mines in 1996, Dr. Quatley[1] advised that he was totally disabled due to his lungs, but he did not state that the miner suffered from black lung. *Tr.* at 21. The miner states that Dr. Forehand is the first physician to communicate a diagnosis of "black lung" to him. *Tr.* at 21.

As in his deposition, Claimant stated that he lasted worked for Canada Coal for less than one year and that, prior to that, he worked for C & O Mining "for over a year." *Tr.* at 29-30. He also reiterated that he worked five to six days a week at C & O Mining and he last worked for this company for one year. *Tr.* at 30. Claimant stated that he currently smokes and started smoking at the age of 18 to 19 years. *Tr.* at 31. He smokes less than one-half a pack of Winston cigarettes per day and has never smoked as much as one pack of cigarettes per day. *Tr.* at 31. He agreed that he had smoked one half a pack of cigarettes per day for 38 years by the time of the hearing. *Tr.* at 31.

## Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

Claimant testified that he last engaged in coal mine employment in 1997 when a physician advised him that he was disabled due to his lung condition. Despite repeated questioning during his October 2002 deposition and at the October 2004 hearing, Claimant consistently denied that he was told in 1997 that he suffered from black lung disease. To the contrary, Claimant states that he was first advised that he suffered from black lung disease by Dr. Forehand. Since Dr. Forehand examined the miner on September 27, 2002, after he filed for benefits on May 8, 2002, his claim is not barred by the limitation of action period.

## Length of Employment

According to the employment histories the Claimant submitted to the Department of Labor and Social Security records, the Claimant began working in the mines in 1971. He left the mines on a physician's recommendation in 1997. DX 2 and 4. The District Director utilized the chart of average annual earnings generated and published by the *Bureau of Labor Statistics* to analyze the Claimant's earnings and determine the number of years of qualifying coal mine employment established by the Claimant. DX 17. The District Director concluded that 25.32 years were established based on the use of this table. This is a reasonable method of calculating the length of coal mine employment as set forth at 20 C.F.R. § 725.101(a)(32) (2005) and, based on these calculations, I find that the Claimant had 25.32 years of coal mine employment.

[1] The physician's name was spelled "Kawatley" during the deposition.

## Responsible Operator

The Claimant testified that he worked at C&O Mining for more than one year. Tr. at 29-30. The President of C&O Mining provided a "Work History & Wage Information Statement on January 8, 1997 stating that Claimant had been employed by the Employer from January 10, 1996 to the "present." DX 33. The District Director found that the Claimant worked for C&O Mining for not less than one year based on Social Security records, the Claimant's deposition testimony, and Employer's personnel records, and pay stubs. DX 35. Although the Employer did not stipulate to its designation as the responsible operator at the hearing, counsel for the Employer stated that "if your Honor had to rely upon that deposition transcript, you would probably find that my client is the Responsible Operator in this case." Tr. at 27. During the deposition, the Employer's counsel noted that Social Security records demonstrate that the Claimant earned $20,737.00 in 1996 and $4,524.00 in 1997 from C&O Mining. Because Claimant's hearing testimony reaffirmed that he worked for C&O Mining and this testimony is supported by documentary evidence of record, I find that C&O Mining has been properly designated as the Responsible Operator for at least one year from January 8, 1996 until some point in 1997. C&O Mining was insured by Hartford Underwriters Insurance Company during the relevant time period. DX 38 and 48. I find that C&O Mining is the Responsible Operator in this case pursuant to 20 CFR §§ 725.491, 492 and 493 (2005).

## Medical Evidence

### Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH) and the registry of physicians' specialties maintained by the American Board of

Medical Specialties.[2] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

| Date of X-ray | Read as Positive for Pneumoconiosis | Read as Negative for Pneumoconiosis | Silent as to the Presence of Pneumoconiosis |
|---|---|---|---|
| 09-27-02 | DX 14<br>Forehand<br>B<br>1/1, q/q<br>Upper four lung zones. | | |
| 09-27-02 | | | DX 15<br>Navani<br>B, BCR<br>Quality reading only.<br>Film quality = 2<br>(overexposed) |

[2] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

| Date of X-ray | Read as Positive for Pneumoconiosis | Read as Negative for Pneumoconiosis | Silent as to the Presence of Pneumoconiosis |
|---|---|---|---|
| 09-27-02 | | DX 41<br>Wiot<br>B, BCR<br>"No evidence of coal workers' pneumoconiosis" | |
| 04-03-03 | DX 40[3]<br>Patel<br>B, BCR<br>2/2, t/u<br>All six lung zones. | | |
| 04-16-03 | DX 42<br>Castle<br>B<br>1/2, r/q<br>Upper four lung zones. | | |
| 02-03-04 | CX 1<br>Mullens[4]<br>unknown (Johnston Memorial Hospital)<br>"Nodular interstitial lung disease consistent with CWP/silicosis." | | |
| 02-03-04 | CX 1<br>Robinette<br>B<br>2/2, r/u<br>All six lung zones. | | |
| 02-03-04 | | EX 3<br>Wheeler<br>B, BCR<br>0/1, q/q<br>Upper four lung zones. | |

[3] In its post-hearing brief, the Employer cites to a July 24, 2003 interpretation by Dr. Wheeler of this study, which was also allegedly located at DX 40. However, upon review of DX 40 and the remaining exhibits of record, I cannot locate any interpretation by Dr. Wheeler of the April 3, 2003 study. Moreover, I note that the District Director did not reference the study in his Proposed Decision and Order at DX 43. As a result, Dr. Wheeler's purported interpretation of the April 2003 study is properly excluded from consideration.

[4] Dr. Mullens is not on the list of NIOSH certified B-readers, nor was I able to locate his board-certifications on http://www.abms.org.

| Date of X-ray | Read as Positive for Pneumoconiosis | Read as Negative for Pneumoconiosis | Silent as to the Presence of Pneumoconiosis |
|---|---|---|---|
| 07-21-04 | EX 5<br>Wheeler[5]<br>B, BCR<br>2/1, q/q<br>Upper four lung zones. | | |

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second ($FEV_1$) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the $FEV_1$ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the $FEV_1$/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

| Ex. No.<br>Date<br>Physician | Age<br>Height[6] | $FEV_1$<br>Pre-/<br>Post | FVC<br>Pre-/<br>Post | $FEV_1$/<br>FVC<br>Pre-/<br>Post | MVV<br>Pre-/<br>Post | Qualify? | Physician Impression |
|---|---|---|---|---|---|---|---|

[5] Dr. Wheeler opined that the nodular infiltrates noted on the study are "tiny calcified granulomata compatible with TB" but he states that "some small nodules could be CWP" and a CT-scan would be helpful. He further notes that "Dr. Ghio at U. North Carolina says these are digital copies (with digital arrow markers) of original films." EX 5. Neither party objected to the admission of this piece of evidence and the Employer is the proffering party and has considered this interpretation as part of the chest x-ray evidence in its post-hearing brief.

[6] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 65" to 66", I have taken the mid-point (65.5") in determining whether the studies qualify to show disability under the regulations.

| Ex. No.<br>Date<br>Physician | Age<br>Height[6] | $FEV_1$<br>Pre-/<br>Post | FVC<br>Pre-/<br>Post | $FEV_1$/<br>FVC<br>Pre-/<br>Post | MVV<br>Pre-/<br>Post | Qualify? | Physician Impression |
|---|---|---|---|---|---|---|---|
| DX 12<br>09-27-02<br>Forehand | 54/65" | 1.70/2.04 | 3.30/3.60 | 51%/56.6% | -- | No<br>Yes | "Pt. very short of breath and complained with chest pains during tests before bronchodilator." DX 12.<br><br>By report dated February 27, 2003, Dr. John Michos validated the study. DX 13. |
| DX 40<br>04-03-03<br>Rasmussen | 54/65" | 1.81/2.30 | 3.71/4.53 | 48.7%/50.7% | 58/86 | No<br>No | |
| DX 42<br>04-16-03<br>Castle | 55/66" | 1.60/1.81 | 3.32/3.64 | 48.2%/49.7% | 50/-- | No<br>Yes | |
| CX 1<br>02-03-04<br>Robinette | 55/65" | 1.56/1.84 | 3.53/4.09 | 44.1%/44.9% | --/-- | No<br>Yes | "Moderate obstructive lung disease with response to bronchodilator therapy. There was evidence of air trapping present. Normal diffusing capacity." CX 1. |
| EX 1<br>07-21-04<br>Ghio | 56/66" | 1.62/1.83 | 3.90/4.08 | 41.5%/44.8% | 43/-- | Yes<br>No | "there is severe obstruction" |

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during

exercise. The blood sample is analyzed for the percentage of oxygen ($PO_2$) and the percentage of carbon dioxide ($PCO_2$) in the blood. A lower level of oxygen ($O_2$) compared to carbon dioxide ($CO_2$) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005).

| Exhibit Number | Date | Physician | $PCO_2$ at rest/ exercise | $PO_2$ at rest/ exercise | Qualify? | Physician Impression |
|---|---|---|---|---|---|---|
| DX 11 | 09-27-02 | Forehand | 36/41 | 75/74 | No/No | |
| DX 40 | 04-03-03 | Rasmussen | 35 | 73 | No | |
| DX 42 | 04-16-03 | Castle | 37.6 | 77.9 | No | |
| CX 1 | 02-03-04 | Robinette | 36.0 | 74.0 | No | |
| EX 1 | 07-21-04 | Ghio | 35 | 94 | No | |

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to this case.

1. Dr. J. Randolph Forehand examined and tested the miner at the request of the Department and issued a report on September 27, 2002. DX 10. He reported 26 years of underground coal

mine employment where Claimant last worked in 1997 as an electrician and miner operator. Dr. Forehand further noted that Claimant was an ongoing smoker and that he started smoking in 1972, and smoked three-quarters of a pack of cigarettes per day. The miner complained of daily sputum production and wheezing, dyspnea for then years with "any activity," cough, and orthopnea. DX 10.

Examination of the lungs revealed crackles at the right base on auscultation. Cardiac examination revealed no significant abnormalities. A chest x-ray was interpreted as revealing Category 1 pneumoconiosis. Ventilatory testing revealed an obstructive ventilatory pattern. Blood gas testing yielded no evidence of hypoxemia at rest or with exercise, nor was there any metabolic disturbance. An EKG demonstrated "no acute changes." Dr. Forehand diagnosed coal workers' pneumoconiosis based on work history, physical examination, chest x-ray, and ventilatory testing. He also diagnosed chronic bronchitis based on history and ventilatory testing. Dr. Forehand attributed the miner's conditions to coal dust exposure and smoking. He concluded that "a significant respiratory impairment is present" and that Claimant had "insufficient residual ventilatory capacity" to perform his last coal mining job. Dr. Forehand stated that the miner was totally disabled. With regard to the etiology of the miner's impairment, Dr. Forehand stated:

> Coal workers' pneumoconiosis and chronic bronchitis combine to impair lung function. The effect of each is additive and chronic bronchitis also aggravates pre-existing coal workers' pneumoconiosis.

DX 10.

2. Dr. Donald Rasmussen examined and tested Claimant at the request of Claimant's counsel and issued a report on April 3, 2003. DX 40. He reported 26 years of coal mine employment, from 1971 to 1996 where Claimant last worked as a continuous miner operator. Dr. Rasmussen described the job as follows:

> He pulled and hung heavy electrical cable. He rock dusted carrying 50# dust bags. He set timbers when pillaring. He helped make belt moves and he shoveled the belt. Thus, he did considerable heavy and some very heavy manual labor.

DX 40. Dr. Rasmussen further noted that Claimant began to smoke regularly at the age of 18 years in 1969 and smoked one-half a pack of cigarettes per day. At the time of Dr. Rasmussen's examination, Claimant reported smoking two to three cigarettes per day. DX 40.

Dr. Rasmussen noted that the miner experienced shortness of breath with exertion for 15 years. Further, he has a chronic productive cough as well as wheezes. Claimant sleeps on two pillows and has orthopnea and paroxysmal nocturnal dyspnea. Examination of the lungs revealed "markedly reduced" breath sounds, with no rales, rhonchi, or wheezes. Cardiac examination revealed reduced heart tones without murmurs, gallops, or clicks. A chest x-ray produced findings of Category 2 pneumoconiosis in all lung zones. An EKG revealed atrial fibrillation with "rapid ventricular response and nonspecific ST-T wave changes." Ventilatory testing demonstrated "moderate, partially reversible obstructive ventilatory impairment."

Claimant's maximum breathing capacity was "markedly reduced" but improved "significantly" after use of a bronchodilator. The single breath carbon monoxide diffusing capacity was normal. Blood gas testing at rest yielded non-qualifying values. No exercise study was conducted due to Claimant's atrial fibrillation. DX 40.

Based on the chest x-ray findings and significant exposure history, Dr. Rasmussen stated that Claimant suffered from coal workers' pneumoconiosis. He noted that smoking and coal dust exposure caused Claimant's chronic obstructive pulmonary disease and bronchitis which, in turn, "are at least partially responsible form Mr. Smith's impaired lung function."

Dr. Rasmussen is board-certified in internal and forensic medicine. He was appointed to the NIOSH Coal Mine Health Research Advisory Committee from 1976 to 1979 and continued to serve under a variety of special appointments with the U.S. government and private sector entities related to coal mine health issues. He has testified before Congress on black lung disease and, in 1969, he was awarded the American Public Health Presidential Award for "exceptional service" in the area of black lung.

3. At Employer's request, Dr. James Castle tested and examined the miner, conducted a review of certain medical records, and issued a report on May 30, 2003. DX 42. He noted that the miner reported difficulty breathing for the last eight to ten years and that he could walk 200 to 300 feet on level ground without stopping due to shortness of breath. Further, Claimant reported that he could "climb one flight of stairs very slowly and would be out of breath when he got to the top." Claimant stated that he had a dry cough and wheezing. DX 42.

Dr. Castle noted that, although Claimant was going to have a cardiac evaluation at Dr. Rasmussen's recommendation, he did not have any chest pain at the time of Dr. Castle's examination. DX 42. Claimant did report a history of asthma, for which he had been treated for ten years. DX 42.

Dr. Castle noted that Claimant smokes one-half a pack of cigarettes per day and started smoking at the age of 19 years. DX 42. Ten years ago, Claimant smoked "almost" one pack of cigarettes per day. Based on this, Dr. Castle credited Claimant with a 30 pack-year smoking history. He also noted a 26 year coal mine employment history, where the miner left in 1997 and last worked as a miner operator. Dr. Castle described the job as follows:

> As a miner operator, (Claimant) had to dig the coal out with a machine and then load it so that it could be transported out of the mine. There was some heavy labor involved as they had to move large cables attached to the miner. He had also worked as an electrician and had shoveled the belt line.

DX 42.

Examination of the lungs revealed no rales, rhonchi, wheezes, rubs, crackles, or crepitations. DX 42. The miner had a normal AP diameter and "[h]e had no intercostal retractions and did not use the accessory muscles with quiet breathing." Cardiac examination revealed an "irregularly irregular rhythm," the "S1 was variable in intensity," and the "PMI" was

"diffuse." A chest x-ray produced findings of Category 1 pneumoconiosis. Ventilatory testing yielded evidence of a "moderate airway obstruction with a significant response to bronchodilators." The total lung capacity showed hyperinflation and there was "significant gas trapping." The diffusing capacity was normal. Dr. Castle concluded that the foregoing findings were "consistent with tobacco smoke induced airway obstruction and bronchial asthma." DX 42.

Blood gas testing produced normal values, which indicated "no impairment of blood gas transfer mechanisms." DX 42. The carboxyhemoglobin level was 2.5 percent. Based on the examination results, Dr. Castle opined that Claimant suffers from simple coal workers' pneumoconiosis, tobacco smoked induced chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. He stated that, when coal workers' pneumoconiosis causes an impairment, "it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect." Claimant did not have these findings–his findings are "indicative of both bronchial asthma and tobacco smoke induced airway obstruction." Because the miner's diffusing capacity was normal, Dr. Castle ruled out the presence of pulmonary emphysema and significant interstitial fibrosis. Dr. Castle further concluded that Claimant was totally disabled "as a result of the pulmonary process." He stated that asthma and smoking-induced airway obstruction caused the total disability–coal workers' pneumoconiosis did not contribute. DX 42.

Dr. Castle is board-certified in internal medicine and pulmonary diseases. DX 42. He is also a NIOSH certified B-reader. He graduated from the West Virginia University School of Medicine and currently serves as a Clinical Professor of Medicine at the University of Virginia College of Medicine. He also works for Pulmonary Medical Associates and Pulmonary Occupational and Research Consultants. Dr. Castle has been a contributing author to numerous publications in his field and has been part of certain abstracts and presentations in his field as well. DX 42.

4. At Claimant's counsel's request, Dr. Emory Robinette examined and tested the miner on February 3, 2004 and issued a report on March 10, 2004. CX 1. Dr. Robinette noted complaints of chronic progressive dyspnea as well as congestion. He reported 26 years of coal mine employment where Claimant operated a continuous miner for the last 15 years. Dr. Robinette noted that, in 1996, Claimant was "removed from the mining industry because of chest x-ray abnormalities." Dr. Robinette further stated that Claimant started smoking at the age of 21 years and "[h]e smoked less than 1 pack of cigarettes per day but he smoked until the date of this exam." The miner complained of shortness of breath "on exertional activity with difficulty climbing hills, steps or inclines." He further reported "chronic cough, chronic congestion and chronic sputum production." Claimant did state that he had "intermittent sharp stabbing right sided chest pain." CX 1.

A chest x-ray revealed Category 2 pneumoconiosis. CX 1. Ventilatory testing demonstrated moderate obstructive lung disease with response to bronchodilator therapy. The miner's total lung capacity and residual volume were elevated. Blood gas testing yielded non-qualifying values. Air trapping was present. An EKG produced evidence of atrial fibrillation. CX 1.

Dr. Robinette diagnosed coal workers' pneumoconiosis based on the chest x-ray with "evidence of auxillary coalescence with emphysema." CX 1. He concluded:

> Clearly Mr. Smith has evidence of an occupational pneumoconiosis which occurred as a direct consequence of his prior coal mining employment. Moreover, there was evidence of severe airflow obstruction … As a consequence of this severe airflow obstruction, Mr. Smith would be unable to work as an underground coal miner. In my medical opinion at least part of his airflow obstruction is directly related to his coal dust inhalation and associated airflow obstruction. This is well described in the pulmonary literature. Unfortunately, Mr. Smith additionally has evidence of atrial fibrillation which may be a new medical problem and will require further evaluation. It is well recognized that cardiac arrhythmias can occur in the setting of significant lung disease …

CX 1.

Dr. Robinette is board-certified in internal medicine with a sub-specialty in pulmonary diseases. CX 1. He is also a NIOSH certified B-reader. In the past, Dr. Robinette served as a Clinical Preceptor for clinical rotations at Johnson Memorial Hospital and he was an Instructor in Clinical Medicine for Respiratory Therapy students from a local community college. In 1985, Dr. Robinette was chair of the Department of Medicine at Johnson Memorial Hospital and, from 1989 to 1990, he served as Chief of Staff at the Hospital. He has also served in other positions at the Hospital over the years, including Pulmonary Consultant, Attending Physician, and Clinical Director of Respiratory Care. Dr. Robinette has also been a contributing author of numerous publications in his field. CX 1.

5. At Employer's request, Dr. Andrew J. Ghio examined and tested the miner, reviewed certain medical records, and issued a report on September 27, 2004. EX 1. The miner complained of "some" shortness of breath with walking less than 100 yards on level ground or going up one flight of stairs. Dr. Ghio further reported that the miner suffers from productive cough and wheezing during the day. Claimant advised that he had been hospitalized in April 2003 for respiratory failure, which required "intubation and mechanical ventilation." EX 1.

Dr. Ghio reported 26 to 27 years of coal mine employment where Claimant stopped working in 1997 due to lung problems. EX 1. He also noted a history of smoking one-half to one pack of cigarettes for 40 years, which equated to a 20 to 40 pack year smoking history. Examination of the lungs revealed decreased breath sounds, but no wheezes. Dr. Ghio noted that "[t]he breath sounds are vesicular except over the airways (midline) where they are bronchial in character." Cardiac examination revealed a "distant S1 S2 with no murmur, gallop, or rub." EX 1.

Ventilatory testing yielded evidence of "severe obstruction" without restriction. EX 1. The diffusing capacity was normal. Dr. Ghio concluded that a "severe respiratory impairment" was present. Blood gas testing produced non-qualifying values. A carboxyhemoglobin level of 2.0 percent indicated an active smoking habit. A chest x-ray yielded evidence of nodular lesions throughout both lung fields but, according to Dr. Ghio, the lesions were not consistent with

pneumoconiosis. They were consistent with an old granulomatous disease such as histoplasmosis or tuberculosis. EX 1.

Dr. Ghio stated that, after consideration of the medical data, Claimant suffers from smoking-induced chronic obstructive pulmonary disease, not coal workers' pneumoconiosis. EX 1. He explained:

> The decreased breath sounds on examination, severe obstruction and hypoxemia on pulmonary function tests, and increased lung volumes on both the pulmonary function tests and X-ray all support chronic obstructive pulmonary disease after cigarette smoking. Chronic obstructive pulmonary disease after exposure to coal dust would not present with such findings on examination, severe obstruction on spirometry, hypoxemia on arterial blood gas testing, and increased lung volumes on pulmonary function testing and the radiograph.

EX 1. Dr. Ghio cited to Drs. Wheeler and Wiot as the more experienced B-readers and noted that they found the x-rays showed chronic granulomatous disease, not coal workers' pneumoconiosis. EX 1.

Dr. Ghio concludes that Claimant is totally disabled due to a smoking-induced respiratory impairment. He noted that "[s]evere obstruction is rare after coal dust exposure while increased lung volumes have never been reported." EX 1.

Dr. Ghio received his medical degree from Boston University School of Medicine. EX 2. He has also taken coursework in public health, statistics, chemistry, and molecular biology. He currently works for the U.S. Environmental Protection Agency as a Research Medical Officer in the National Health and Environmental Effects Research Laboratory. He is also an Associate Consulting Professor of Medicine at the Division of Pulmonary and Critical Care Medicine in Durham, North Carolina. He is board-certified in internal medicine and pulmonary diseases. Dr. Ghio is also board-eligible for occupational medicine. He has been involved in a variety of journal reviews and is the recipient of numerous professional awards, recognitions, and grants. He has teaching and clinical responsibilities at Duke University School of Medicine and Medical Center as well as the University of North Carolina School of Medicine and Medical Center. He also has a variety of medically-related patents. Dr. Ghio has been the contributing author of numerous publications, including publications related to pulmonary diseases. EX 2.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and bronchitis, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the miner filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *U.S. Mining Co. v. Director, OWCP*, 386 F.3d 977 (11th Cir. 2004); *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the five chest x-ray studies available in this case, there are six positive and two negative interpretations. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The September 2002 study was interpreted by Dr. Forehand, a B-reader, as positive for the existence of pneumoconiosis. On the other hand, Dr. Wiot, a dually-qualified physician, concluded that the study did not reveal evidence of coal workers' pneumoconiosis. Dr. Forehand's *curriculum vitae* is not in the record. However, he is board-certified in pediatrics as well as allergy and immunology.[7] He is also a B-reader, which means that the NIOSH has concluded that he is proficient in reviewing chest x-rays for the presence of pneumoconiosis. Dr. Wiot graduated from the University of Cincinnati College of Medicine. He has served on the American College of Radiology Task Force on Pneumoconiosis since 1969, including serving as Chair of the Committee for several years. Dr. Wiot has also served as a Radiological Consultant for the U.S. Public Health Service as well as Chair of the Workgroup of ILO Classification System from 1988 to 1990. Dr. Wiot has been a contributing author to several publications in his field and currently serves as a Consultant to the *Journal of Occupational Medicine.* He has

[7] Dr. Forehand's board-certifications were obtained from www.abms.org.

served as a consultant to committees that address medical standards for diagnosing coal workers' pneumoconiosis. On balance, Dr. Wiot's negative interpretation is accorded greater weight because of his superior radiological qualifications.

The April 3, 2003 study was interpreted as positive by Dr. Patel. Dr. Patel's *curriculum vitae* is not in the record. However, as previously noted, he is a board-certified radiologist and B-reader. There are no contrary readings of the study such that it supports a finding of pneumoconiosis.

Similarly, the record contains an uncontradicted B-reading by Dr. Castle of the April 16, 2003 study. Dr. Castle graduated from the West Virginia University School of Medicine. He serves as a Clinical Professor of Medicine at the University of Virginia College of Medicine. Dr. Castle also works for Pulmonary Medical Associates and Pulmonary Occupational and Research Consultants, where he is the Principal Investigator for Clinical Study Trials. He is board-certified in internal medicine and pulmonary diseases. Dr. Castle has been a contributing author to numerous publications in his field. Given that Dr. Castle has been certified by NIOSH as proficient in reviewing chest x-rays for the presence of pneumoconiosis, this study supports a finding of pneumoconiosis.

The February 2004 study was interpreted as positive for the presence of pneumoconiosis by Dr. Robinette, a B-reader, as well as Dr. Mullens whose radiological qualifications are unknown. While Dr. Wheeler, a dually-qualified physician, concluded that the February 2004 study revealed Category 0/1 pneumoconiosis, he then found that a July 2004 study demonstrated Category 2 pneumoconiosis. Dr. Wheeler's interpretation of this latest study is uncontradicted. As previously noted, Dr. Robinette is board-certified in internal medicine and pulmonary diseases.[8] He has served as an Instructor to Medical Residents and Medical Students. In the past, Dr. Robinette also held positions of Chief of Staff, Chair of the Department of Medicine, and Chair of the Critical Care Committee at the Johnston Memorial Hospital in Abingdon, Virginia. He has also served as Pulmonary Consultant and Clinical Care Director of Respiratory Care Services at the Hospital. He has been a contributing author of some publications in his field. Dr. Mullens' qualifications are not in the record. Dr. Wheeler graduated from Harvard Medical School and is board-certified in radiology. He serves as an Associate Professor of Radiology at the Johns Hopkins Medical Institutions. Dr. Wheeler has made numerous presentations and contributed to a wide variety of publications in his field, including publications related to occupational lung disease. Dr. Wheeler has superior qualifications and has provided Category 0 and Category 2 interpretations of studies of February and July 2004, respectively. Given the temporal proximity of the studies, I find that Dr. Wheeler's Category 2 interpretation of the June 2004 study is the most probative and it supports a finding of pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to the Claimant's current claim. I find that the x-ray evidence establishes the existence of pneumoconiosis. As I have found that the majority of recent x-rays interpreted for pneumoconiosis were positive, and that the positive interpretations are entitled to greater weight than the negative interpretations, I

[8] Although Dr. Robinette's *curriculum vitae* is in the record, the first page is missing. Therefore, Dr. Robinette's board certifications were obtained from www.abms.org.

conclude that the Claimant has established the existence of pneumoconiosis by virtue of the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).

I am mindful that an administrative law judge must consider a medical report as a whole, *see Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988), and *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984), and may not discredit an opinion merely because it is based on an x-ray interpretation which is outweighed by the other x-ray interpretations of record. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986); *cf. Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989). Nevertheless, where x-ray evidence constitutes an apparent major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that specific film has been reread as negative, and the administrative law judge makes a specific finding to that effect. *See generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6 (6th Cir. 1983).

As the Court cautioned in *Underwood v. Elkay Mining, Inc*.,105 F.3d 946, 950-951 (4th Cir. 1997):

> In *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992), we pointed out that in considering expert opinions, merely 'counting heads' with the underlying presumption that two expert opinions ipso facto are more probative than one is a hollow endeavor and contributes little when weighing evidence. Id at 52. While we recognize that merely counting heads is not the appropriate manner for the ALJ to weigh numerous and diverse opinions, we did not suggest that two or three independent qualified opinions were necessarily of less probative value than one. In weighing opinions, the ALJ is called upon to consider their quality. Thus, the ALJ should consider the qualifications of the experts, the opinions' reasoning, their reliance on objectively determinable symptoms and established science, their detail of analysis, and freedom from irrelevant distractions and prejudices.…

In determining whether pneumoconiosis exists in this case, I must also consider the holding of the United States Court of Appeals for the Fourth Circuit in *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995) that "chronic obstructive lung disease … is encompassed within the definition of pneumoconiosis for the purpose of entitlement to Black Lung benefits." 60 F.3d at 175. The Court found that the assumptions of physicians that obstructive disorders cannot be caused by coal mine employment or that a diagnosis of pneumoconiosis cannot be made without x-ray or tissue samples to be erroneous. Citing *Eagle v. Armco, Inc*., 943 F.2d 509 (4th Cir. 1991), the Court noted that "the opinion of an expert 'that breathing coal mine dust does not cause chronic obstructive lung disease … must be considered bizarre in view of [ ] Congress' explicit finding to the contrary.'" 60 F.3d at 174-175 (Citations omitted).

Initially, with regard to the presence of clinical pneumoconiosis, the opinions of Drs. Forehand, Rasmussen, Castle, and Robinette are more probative than Dr. Ghio's opinion as they are better supported by a preponderance of the objective medical data of record, *i.e.* the preponderantly positive chest x-ray interpretations. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986).

Turning to the issue of legal coal workers' pneumoconiosis, I note that Drs. Forehand, Rasmussen, and Robinette diagnose the Claimant with coal dust and smoking-induced obstructive lung disease. Drs. Rasmussen and Forehand also diagnose the presence of coal dust induced chronic bronchitis. Drs. Ghio and Castle, on the other hand, conclude that the miner does not suffer from legal coal workers' pneumoconiosis; rather, according to these physicians, he suffers only from smoking-induced chronic obstructive pulmonary disease.

The conflicting medical opinions must be weighed to resolve the contrary conclusions. As an initial matter, all of the physicians noted 26 years of coal mine employment. However, smoking histories noted by the physicians varied. Dr. Forehand reported that the miner has smoked three-quarters of a pack of cigarettes per day since 1972. Dr. Rasmussen stated that the Claimant started smoking one-half a pack of cigarettes per day since 1969. He further noted that the Claimant continues to smoke two to three cigarettes per day. Dr. Castle credited the miner with a 30 pack year smoking history and reported that the Claimant currently smokes one-half a pack of cigarettes per day. Dr. Robinette noted that the miner has smoked less than one pack of cigarettes per day since the age of 21 years (1969). Finally, Dr. Ghio noted a 20 to 40 pack year history of smoking cigarettes. These smoking histories translate to approximately the following:

| | |
|---|---|
| Dr. Forehand | 22.5 pack years |
| Dr. Rasmussen | 17 pack years |
| Dr. Castle | 30 pack years |
| Dr. Robinette | 17.5 pack years |
| Dr. Ghio | 20-40 pack years |

During his deposition, the Claimant testified that he smoked one-half to three quarters a pack of cigarettes per day and has done so since the age of 16 or 17 years. At the hearing, the Claimant testified that he currently smokes less than one-half a pack of Winston cigarettes per day. He agreed with opposing counsel on cross-examination, that he has smoked one-half a pack of cigarettes for 38 years.

The Benefits Review Board has held that an Administrative Law Judge may properly discount a physician's opinion as to the causation of a miner's respiratory or pulmonary condition when it is based on an inaccurate understanding of the miner's smoking history. See *Risher v. Director, OWCP*, 940 F.2d 327, 330-31 (8th Cir. 1991); *Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1983). Based on the foregoing hearing testimony, I find that the miner has a 19 pack year history of smoking cigarettes. All of the physicians, except for Drs. Castle and Ghio, based their opinions on a smoking history consistent with my finding. Dr. Castle's opinion is compromised because it is based on a significantly disparate smoking history of ten pack years greater than that established on this record. Dr. Ghio considers a widely varying smoking history of 20 to 40 pack years. This is problematic considering that Dr. Ghio interviewed the Claimant and had an opportunity to be much more precise regarding his smoking history. Given the imprecision of Dr. Ghio's reported smoking history, which would have an impact on his opinion regarding the existence of a coal dust-induced or smoking-induced disease, his report is accorded less probative value.

Additionally, the reasoning underlying Dr. Ghio's report is somewhat confusing. At one point, he states that the miner does not suffer from coal workers' pneumoconiosis because the "severe obstruction" observed in this case is rarely caused by coal dust exposure. Then, he posits that "severe obstruction has never been reported in the medical literature to be associated with exposure to coal dust." This later statement is contrary to the Department's position, which is based on a review of a significant body of medical literature and studies. In its comments to the amended regulations, the Department states there is "overwhelming scientific and medical evidence demonstrating that coal dust exposure can cause obstructive lung disease." 65 Fed. Reg. 79944 (Dec. 20, 2000). The Department has further concluded that the risks of smoking and coal dust exposure to the development of obstructive lung disease are additive. 65 Fed. Reg. 79940 (Dec. 20, 2000). Dr. Ghio acknowledged that the Claimant's symptoms of shortness of breath, cough, phlegm, and wheezing can be consistent with coal workers' pneumoconiosis, but these non-specific findings could also be the result of other disease processes such as smoking-induced chronic obstructive pulmonary disease. Overall, I find that Dr. Ghio's report is less persuasive as he relies on a widely disparate smoking history and his opinion contains confusing reasoning.

Dr. Castle concluded that the miner suffered from smoking induced obstructive lung disease as well as bronchial asthma. In support of his opinion, he noted hyperinflation, gas trapping, reversibility on ventilatory testing, and a normal diffusing capacity. I note that reversibility on ventilatory testing does support a diagnosis of asthma and is not consistent with a progressive and irreversible lung disease such as coal workers' pneumoconiosis. This reversibility, which is significant enough to bring the miner's pulmonary function values from qualifying to non-qualifying, leads me to conclude that Dr. Castle's finding that the Claimant does not suffer from legal coal workers' pneumoconiosis has merit despite the inaccurate smoking history reported by Dr. Castle.

In support of the miner's claim, Drs. Forehand, Rasmussen, and Robinette conclude that he suffers from clinical and legal coal workers' pneumoconiosis. As previously noted, their findings of clinical coal workers' pneumoconiosis are properly supported by the preponderantly positive chest x-ray interpretations. On the other hand, in concluding that the miner's obstructive lung disease is due to coal dust exposure as well as smoking, the opinions of Drs. Forehand, Rasmussen, and Robinette are not well-reasoned. They rendered conclusory opinions and failed to address and explain reversibility of the obstruction exhibited on the miner's ventilatory testing.

After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Forehand, Rasmussen, Castle, and Robinette in their diagnosis of clinical coal workers' pneumoconiosis as it is supported by the preponderantly positive chest x-ray interpretations of record. All four physicians examined the Claimant and Drs. Rasmussen, Castle, and Robinette possess excellent credentials in the areas of internal medicine and pulmonary diseases. Although Dr. Ghio possesses impressive qualifications, his finding of no clinical coal workers' pneumoconiosis is contrary to my findings based on all the evidence of record. Moreover, he relies on an imprecise smoking history and offers confusing reasoning in concluding that the miner does not suffer from legal coal workers' pneumoconiosis such that his opinion loses probative force. However, despite reliance on an inaccurate smoking history, Dr. Castle's conclusion that the miner's obstructive lung disease is not coal dust related because of reversibility on ventilatory testing is well-documented and well-reasoned. Drs. Forehand, Rasmussen, and Robinette fail to address the reversibility and, as a result, their finding of legal coal workers' pneumoconiosis is not persuasive.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinions of Drs. Forehand, Rasmussen, Robinette, and Castle to merit greater probative weight in the diagnosis of clinical coal workers' pneumoconiosis. I find that Dr. Castle's opinion that the miner does not suffer from legal coal workers' pneumoconiosis outweighs the contrary opinions of Drs. Forehand, Rasmussen, and Robinette. I conclude, therefore, that the weight of the medical opinions of record establishes that the Claimant suffers from clinical coal workers' pneumoconiosis, but that he does not suffer from legal coal workers' pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). The Claimant was employed as a miner for 25.32 years and, therefore, is entitled to the presumption. Of the physicians offering medical opinions, Drs. Forehand, Rasmussen, Robinette, and Castle agree that the miner suffers from simple clinical coal workers' pneumoconiosis. Their medical opinions are supported by chest x-rays interpreted as positive by Drs. Forehand, Patel, Castle, Mullens, and Robinette. Dr. Wiot concluded that the September 2002 study was not positive for the presence of coal workers' pneumoconiosis and he stated the following:

> There is an ill-defined density within the left upper lung field that appears to be pleural in nature. Pleural disease is not a manifestation of coal dust exposure. There are a few calcified granulomatous lymph nodes on the right. The chest is otherwise unremarkable.

DX 41. Nearly two years later, Dr. Wheeler concluded that a study conducted on July 21, 2004 demonstrated Category 2 pneumoconiosis. Because pneumoconiosis is progressive and irreversible, Dr. Wheeler's subsequent interpretation contains a better assessment of the current condition of the Claimant's lungs.[9] However, he commented that this pneumoconiosis may be due to coal dust exposure:

> Minimal ill defined mixed irregular and small nodular infiltrates mainly in right apex and lateral portion mid and upper lungs involving pleura mixed with small calcified granulomata with minimal right apical pleural thickening and probable calcified granulomata in hila compatible with TB or histoplasmosis at least partially healed.
>
> . . .
>
> Some small nodules could be cwp [coal workers' pneumoconiosis] but pattern is asymmetrical, mainly peripheral and in right apex which all favors TB.
>
> Get CT scan for better evaluation and compare to old films because an exact diagnosis is needed.

Dr. Wheeler's equivocal statements regarding etiology are insufficient to rebut the presumption. There is no evidence that the Claimant suffers from tuberculosis and, without a medical basis, Dr. Wheelers' speculations as to the cause of the nodules on the x-ray are less probative.

Consequently, I find that the Claimant is entitled to invocation of the rebuttable presumption that his pneumoconiosis is coal dust related and the Employer has presented insufficient evidence to rebut the presumption.

---

[9] Notably, the July 21, 2004 study was conducted during Dr. Ghio's examination of the Claimant. In his report, Dr. Ghio stated that Drs. Wheeler and Wiot are the radiologists "most experienced in B reading." He further states that "[t]hese same physicians also lead the field of chest radiology and their opinions are valued."

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131, 1-133–134 (1986). Little or no weight may be accorded to a ventilatory study if the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co*., 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945, 1-946–947 (1984); *Justice v. Jewell Ridge Coal Co*., 3 B.L.R. 1-547, 1-551 (1981).

In this case, the September 2002, April 16, 2003, February and July 2004 ventilatory studies yielded qualifying values prior to use of a bronchodilator, but the values were non-qualifying after its use. Dr. Rasmussen's April 3, 2003 study produced non-qualifying values before and after use of a bronchodilator. None of the studies has been invalidated. Overall, these studies do not establish the presence of an irreversible, disabling pulmonary impairment. To the contrary, with the use of medication, the Claimant's pulmonary function values are consistently non-qualifying. As a result, I find that the Claimant has not established total disability through the ventilatory testing of record.

Turning to the blood gas study evidence, I note that none of the resting or exercise studies produced qualifying values. As a result, the Claimant has not demonstrated total disability through the blood gas study evidence of record.

On the other hand, all physicians who examined the Claimant or reviewed his records agree that the Claimant suffers from a totally disabling respiratory or pulmonary impairment. The Claimant last worked as a continuous miner operator and electrician. As previously noted, he testified that he had to crawl "[a]ll day" and move heavy cables in the performance of his job.

As a result, the Claimant's last coal mine job required moderate to heavy manual labor. Although blood gas testing produced non-qualifying values and ventilatory studies yielded non-qualifying values after use of a bronchodilator, the physicians have properly based their findings of a totally disabling respiratory impairment on physical examinations and observations of the miner as well as consideration of the miner's symptoms in comparison to the exertional requirements of his last coal mining job. There are no contrary opinions of record and, as a result, I find that the medical opinion evidence establishes that the miner suffers from a totally disabling respiratory or pulmonary impairment.

Causation of Total Disability

While all of the physicians have diagnosed the presence of a totally disabling respiratory impairment, there is conflict regarding the etiology of this impairment. Drs. Forehand, Rasmussen, and Robinette concluded that the miner suffered from clinical and legal coal workers' pneumoconiosis and these conditions, along with smoking-induced respiratory disease, contributed to the miner's overall totally disabling respiratory impairment. Dr. Castle agreed that the miner suffered from clinical coal workers' pneumoconiosis, but he concluded that the miner's totally disabling respiratory impairment was due solely to smoking-induced lung disease. Dr. Ghio concluded that the miner suffered from neither clinical nor legal coal workers' pneumoconiosis, but opined that the miner's totally disabling respiratory impairment was due to asthma and tobacco-induced lung disease.

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2005); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990).

The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990).

Initially, I note that Dr. Ghio concluded that the miner suffered from neither clinical nor legal coal workers' pneumoconiosis, which is contrary to my findings based on the medical record as a whole. In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded

that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002). Based on the foregoing, Dr. Ghio's opinion regarding the cause of the miner's respiratory disability is accorded less weight.

Dr. Castle concluded that, because the miner's diffusing capacity was normal, then he could rule out the presence of pulmonary emphysema and significant interstitial fibrosis. From this, Dr. Castle concluded that the miner was totally disabled due to asthma and smoking-induced airway obstruction. On the other hand, Drs. Rasmussen and Forehand conclude that coal dust exposure and smoking each contributed to the miner's disabling respiratory impairment. After finding that the miner had clinical coal workers' pneumoconiosis, Dr. Rasmussen stated:

> The two or possibly three risk factors are his cigarette smoking and coal mine dust exposure. Cigarette smoking and coal mine dust exposure cause chronic obstructive pulmonary disease, i.e., emphysema and bronchitis. Both are at least partially responsible for Mr. Smith's impaired lung function. Asthma or hyperactive airways disease makes an individual more susceptible to the effects of inhaled toxins such as cigarette smoking and coal mine dust exposure. The patient's coal mine dust exposure, thus, is a significant contributing factor.

Dr. Forehand concluded:

> Coal workers' pneumoconiosis and chronic bronchitis combine to impair lung function. The effect of each is additive and chronic bronchitis also aggravates preexisting coal workers' pneumoconiosis.

As previously noted, Dr. Robinette attributed the miner's disabling obstructive airways disease to coal dust exposure.

Of these opinions, I find that Drs. Castle and Rasmussen are the only physicians to directly address the reversible, or asthmatic, component of the miner's lung disease in assessing the etiology of his overall respiratory disability. Dr. Castle relies on the miner's normal diffusing capacity to conclude that he does not suffer from significant interstitial fibrosis or pulmonary emphysema and his disabling respiratory impairment is due solely to smoking-

induced obstructive lung disease. However, normal diffusing capacity, standing alone, does not preclude a finding that coal workers' pneumoconiosis contributed to the miner's overall disability. Although ventilatory testing revealed significant reversibility of the miner's lung function, there was still a residual, irreversible component to the ventilatory function that the physicians of record agree was totally disabling. Moreover, objective data of record demonstrates that the miner's pneumoconiosis progressed from Category 1 during Dr. Castle's April 16, 2003 examination to Category 2 during Dr. Ghio's examination more than one year later on July 21, 2004. Dr. Rasmussen states that the miner's asthma or hyperactive airways disease makes him "more susceptible to the effects of inhaled toxins such as cigarette smoking and coal mine dust exposure." In this case, the miner's lung disease has progressed and part of his disabling ventilatory dysfunction is irreversible. This is consistent with Dr. Rasmussen's opinion that coal workers' pneumoconiosis along with smoking-induced lung disease contributed to the miner's disability and that the miner's asthma left him "more susceptible to the effects of inhaled toxins" of coal dust and tobacco.

Drs. Castle and Robinette are board-certified in internal medicine and pulmonary diseases and they are NIOSH certified B-readers. Dr. Rasmussen completed residencies in internal medicine and pulmonary diseases. He is a NIOSH certified B-reader and has board-certifications in internal medicine, forensic medicine, and forensic examiners. Dr. Forehand is board-certified in pediatrics and allergy and immunology.

Of these physicians, Dr. Rasmussen is the most qualified on this record. Dr. Castle has been the author of published works in the field of internal medicine and pulmonary diseases. He serves as a clinical professor. However, Dr. Rasmussen has the most significant background in the study and treatment of occupational lung diseases in general and coal workers' pneumoconiosis in particular. He has been immersed in this area of medicine since at least 1969 when he received the American Public Health Association's Presidential Award for "exceptional service in the fight against black lung." Since that time, he has been appointed to serve on several NIOSH and United Mine Workers of America committees addressing issues related to coal workers' pneumoconiosis. Dr. Rasmussen has also testified before both houses of the United States Congress as well as the West Virginia State Legislature on issues related to occupational pneumoconiosis. In sum, the focus of Dr. Rasmussen's long-term and distinguished medical career has been the study of occupational pneumoconiosis. For these reasons, it is determined that he is the most qualified physician offering an opinion in this record.

Based on the foregoing, I find that the Claimant has demonstrated that his totally disabling respiratory impairment is due, at least in part, to coal workers' pneumoconiosis.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR § 725.503(b) (2005). The Claimant filed his claim for benefits in May 2002. When he was examined by Dr. Forehand in September 2002, he was already totally disabled due, in part, to coal workers' pneumoconiosis. There is no medical evidence prior to Dr. Forehand's opinion that enables me to pinpoint the

precise date on which the Claimant became totally disabled due to coal workers' pneumoconiosis. Accordingly, I find that the Claimant is entitled to benefits commencing on May 2002, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden of demonstrating that he is totally disabled due to coal workers' pneumoconiosis and is, therefore, entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2005). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Robert C. Smith is hereby GRANTED and the Employer, C & O Mining Incorporated, shall pay all benefits to which he entitled under the Act commencing as of May 2002, the date on which this claim was filed, to be augmented by reason of the Claimant's dependent spouse, Judy.

A

ALICE M. CRAFT
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS**: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is:

**Benefits Review Board**
**U.S. Department of Labor**
**P.O. Box 37601**
**Washington, DC 20013-7601**

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark,

or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).